

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11164

Reg. Dist. No. 51

11171

1. PLACE OF DEATH a. COUNTY <u>Cabnet</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabnet</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabnet County Hospital</u>				d. STREET ADDRESS _____			
3. NAME OF DECEASED (Type or print) <u>ALONZA W. HAMMETT</u>				4. DATE OF DEATH <u>Nov. 28, 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 29, 1881</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Art. Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Calif. Prince St. Mary's Co.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Lytleton S. Hammett</u>			
14. MOTHER'S MAIDEN NAME <u>Jennie E. Williams</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>?</u>				17. INFORMANT <u>Lytleton Gray - Prince Frederick, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>11-28</u> , 19 <u>56</u> , to <u>11-28</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>11-28</u> , 19 <u>56</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Wallace McNeil</u> M.D.				ADDRESS (Street, city or town, state) <u>Prince Frederick, Md</u>			
DATE SIGNED <u>11/30/56</u>				PHYSICIAN'S NAME (Type) <u>J. WALLACE McNEIL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Central Methodist Cems. Bn. - Cabnet Co. - Md.</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. A. Harkness & Son - Mutual, Md</u>				24a. REC'D BY REGISTRAR <u>DATE 12-1-56</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>14. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>15. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>16. SIGNATURE OF CHURCH [Faint text]</p>	
<p>17. SIGNATURE OF MINISTERS [Faint text]</p>		<p>18. SIGNATURE OF OTHER [Faint text]</p>	
<p>19. SIGNATURE OF OTHER [Faint text]</p>		<p>20. SIGNATURE OF OTHER [Faint text]</p>	
<p>21. SIGNATURE OF OTHER [Faint text]</p>		<p>22. SIGNATURE OF OTHER [Faint text]</p>	
<p>23. SIGNATURE OF OTHER [Faint text]</p>		<p>24. SIGNATURE OF OTHER [Faint text]</p>	
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<p>57. SIGNATURE OF OTHER [Faint text]</p>		<p>58. SIGNATURE OF OTHER [Faint text]</p>	
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<p>61. SIGNATURE OF OTHER [Faint text]</p>		<p>62. SIGNATURE OF OTHER [Faint text]</p>	
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<p>67. SIGNATURE OF OTHER [Faint text]</p>		<p>68. SIGNATURE OF OTHER [Faint text]</p>	
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<p>71. SIGNATURE OF OTHER [Faint text]</p>		<p>72. SIGNATURE OF OTHER [Faint text]</p>	
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<p>87. SIGNATURE OF OTHER [Faint text]</p>		<p>88. SIGNATURE OF OTHER [Faint text]</p>	
<p>89. SIGNATURE OF OTHER [Faint text]</p>		<p>90. SIGNATURE OF OTHER [Faint text]</p>	
<p>91. SIGNATURE OF OTHER [Faint text]</p>		<p>92. SIGNATURE OF OTHER [Faint text]</p>	
<p>93. SIGNATURE OF OTHER [Faint text]</p>		<p>94. SIGNATURE OF OTHER [Faint text]</p>	
<p>95. SIGNATURE OF OTHER [Faint text]</p>		<p>96. SIGNATURE OF OTHER [Faint text]</p>	
<p>97. SIGNATURE OF OTHER [Faint text]</p>		<p>98. SIGNATURE OF OTHER [Faint text]</p>	
<p>99. SIGNATURE OF OTHER [Faint text]</p>		<p>100. SIGNATURE OF OTHER [Faint text]</p>	

BUREAU V. S.

DEC 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11172 CERTIFICATE OF DEATH

Reg. Dist. No. 11165

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>53 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Calvert Co., Hospital</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>Harrison</u> Last <u>Harrison</u>		4. DATE OF DEATH Month <u>II</u> Day <u>25</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-I-1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas R. Norfolk</u>		14. MOTHER'S MAIDEN NAME <u>Emily Cross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Russell Wood Friendship, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/10</u> , 19 <u>40</u> , to <u>11/24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/24</u> , 19 <u>56</u> , and that death occurred at <u>1:42</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Huntingtown Md</u> DATE SIGNED <u>11/25/56</u> ACTUAL SIGNATURE <u>Dr. George J. Weems</u> M.D. <u>Dr. George J. Weems</u> PHYSICIAN'S NAME (Type) <u>Dr. George J. Weems</u> <u>Huntingtown Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/27/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Miranda Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingtown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Grace L. Hutchins</u>		ADDRESS <u>Owings, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Grace L. Hutchins</u>		24b. REGISTRAR'S SIGNATURE <u>Grace L. Hutchins</u>	
DATE <u>11/27/56</u>			

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11173

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11166

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamlet</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co</u>		d. STREET ADDRESS <u></u>	
3. NAME OF DECEASED (Type or print) <u>Eugene Fred Holland</u> First Middle Last		4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 4. 56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Nathaniel Holland</u>		14. MOTHER'S MAIDEN NAME <u>Mamie U. Stepney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Upper respiratory infection</u> 475x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Head trauma at birth</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11-23-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Sevierland md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Pa. Fred md</u>		24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	
DATE <u>11-23-58</u>			

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RECEIVED

NOV 26 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH o. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Cabaret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>—</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>TERRI</u> Middle <u>W.</u> Last <u>JONES</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1955</u>	
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>25</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Cabaret County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Claude Jones</u>				14. MOTHER'S MAIDEN NAME <u>Rita Coburn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Claude Jones - Solomons Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> <u>752X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>—</u> , 19 <u>—</u> , to <u>—</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>—</u> , 19 <u>—</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H W Ward</u>				ADDRESS (Street, city or town, state) <u>Owings Md</u>			
PHYSICIAN'S NAME (Type) <u>H. W. WARD</u>				DATE SIGNED <u>11/21/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Nov. 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Solomons Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Solomons Cabaret - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. G. Harkness & Son - Mutual, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>11-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

2064 201386

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11107

BUREAU V. 3

NOV 26 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG210 2-18-57 et

11168

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH o. COUNTY CALVERT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CALVERT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCE FREDERICK		c. LENGTH OF STAY IN 1b OCT 3 - NOV 9	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CALVERT COUNTY HOSPITAL ANNEX		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First SALLIE Middle ANN Last KING		4. DATE OF DEATH Month 11 Day 9 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 6 1875
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PARIS		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME RICHARD MARGUSS		14. MOTHER'S MAIDEN NAME SARAH ANN MCROSBY - CALVERT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1/1955 to 11/9/1956 , that I last saw the deceased alive on 11/8/1956 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Huntingtown, Md DATE SIGNED 11/10/56			
ACTUAL SIGNATURE G. J. Weems		M.D. G. J. Weems	
PHYSICIAN'S NAME (Type) G. J. WEE MS			
22a. BURIAL - CREMATION 11-12-56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Mt Harmony		22d. LOCATION (City, town, or county) (State) Mt. Quyns Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm H. Hutchins		ADDRESS Quyns Md.	
24a. REC'D BY REGISTRAR DATE 11/12/56		24b. REGISTRAR'S SIGNATURE Grace L. Hutchins	

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NOV 19 1956

BUREAU V. 3

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME		GARY, T	
DATE OF BIRTH		JULY 7, 1924	
PLACE OF BIRTH		WEST COUNTY, MARYLAND	
SEX		MALE	
RACE		WHITE	
RELIGION		METHODIST	
MARRIED		YES	
WIFE'S NAME		ANN	
DATE OF MARRIAGE		JULY 1, 1948	
PLACE OF MARRIAGE		BALTIMORE, MARYLAND	
OCCUPATION		FARMER	
CAUSE OF DEATH		HEART DISEASE	
DATE OF DEATH		JULY 1, 1956	
PLACE OF DEATH		BALTIMORE, MARYLAND	
SIGNATURE OF DECEASED		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF MINISTER		[Signature]	
SIGNATURE OF CORONER		[Signature]	
SIGNATURE OF JUDGE		[Signature]	
SIGNATURE OF CLERK		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner poppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11176 CERTIFICATE OF DEATH

11169
Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write Prince Frederick) RURAL and give nearest town)		c. LENGTH OF STAY IN b. 3 Days	
c. CITY OR TOWN (If outside corporate limits, write Prince Frederick) RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) Louis First Morsell Middle Morsell Last		4. DATE OF DEATH 11 Month 22 Day 1956 Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-1887
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Morsell sr.		14. MOTHER'S MAIDEN NAME Beretta Morsell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-161227A	
17. INFORMANT Wife--Mary Morsell Address Prince Frederick, md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C.V. disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/26 , 19 56 , to 11/22 , 19 56 , that I last saw the deceased alive on 11/22 , 19 56 , and that death occurred at 4:10 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. W. Ward		ADDRESS (Street, city or town, state) Huntingtown DATE SIGNED 11/26/56	
PHYSICIAN'S NAME (Type)			
22a. (BURIAL) CREMATION, REMOVAL (Specify) 11-25-56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Calvert Co. md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Sewell ADDRESS Prince Frederick, md		24a. REC'D BY REGISTRAR 11-25-56 DATE	
24b. REGISTRAR'S SIGNATURE H. W. Ward			

BUREAU V. S.

NOV 28 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11170
11177 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY CALVERT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD. b. COUNTY CALVERT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCE FREDERICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CALVERT CO. HOSP.		d. STREET ADDRESS H	
3. NAME OF DECEASED (Type or print) First EDWARD Middle STEPNEY Last STEPNEY		4. DATE OF DEATH Month 11 Day 10 Year 19 56	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept-17.
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dennis Stepney		14. MOTHER'S MAIDEN NAME Marion Chase	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-26-4441	
17. INFORMANT Mama Stepney		Address Huntingtown, md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND OF DUE TO 981X THE HEART Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) THE HEART (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SHOT AT DUKES TAVERN	
20c. TIME OF INJURY Month, Day, Year 8:45 p.m. 11-10 19 56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) TAVERN	20f. (City or town) PRINCE FREDERICK (County) CALVERT (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. E. Sewell MD M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R. E. Sewell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-11-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-15-56	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Patuxent	22d. LOCATION (City, town, or county) Huntingtown (State) md
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell ADDRESS P. E. Sewell Co. Fred. Md		24a. REC'D BY REGISTRAR DATE 11/14/56	24b. REGISTRAR'S SIGNATURE H. W. Ward

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME SEX AGE RACE OCCUPATION PLACE OF BIRTH PLACE OF DEATH DATE OF DEATH TIME OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF EXAMINER OFFICE OF EXAMINER CITY STATE ZIP CODE		SEX AGE RACE OCCUPATION PLACE OF BIRTH PLACE OF DEATH DATE OF DEATH TIME OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF EXAMINER OFFICE OF EXAMINER CITY STATE ZIP CODE
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BUREAU V. 3

NOV 15 1956

RECEIVED

11178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY CALVERT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD. b. COUNTY CALVERT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCE FREDERICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CALVERT CO. HOSP.		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First LEWIS Middle WILLIAM Last STEPNEY		4. DATE OF DEATH Month 11 Day 10 Year 1956	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months 31 Days 10 Hours 19 Min. 56	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dennis Stepney	
14. MOTHER'S MAIDEN NAME Marie Chase		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 219-16-2013		17. INFORMANT Mrs Anne Chase Barstow md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BUL SHOT WOUND OF DUE TO 981x Conditions, if any, which gave rise to immediate cause (b) THE HEART (c) THE HEART DUE TO (c) THE HEART PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SHOT AT DUKES TAVERN			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SHOT AT DUKES TAVERN	
20c. TIME OF INJURY Month, Day, Year 84 Hour 10-10 19 56 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) TAVERN		20f. (City or town) (County) (State) PRINCE FREDERICK CALVERT	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. E. Seewell		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) P. E. Seewell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-11-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-15-56		22b. DATE THEREOF Patuxent	
22c. NAME OF CEMETERY OR CREMATORY Huntington		22d. LOCATION (City, town, or county) (State) md	
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Seewell		ADDRESS Pr. Fred. md	
24a. REC'D BY REGISTRAR DATE 11/14/56		24b. REGISTRAR'S SIGNATURE H. W. Ward	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

NOV 15 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11172
11179 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Cornie Mae Watkins</i> First <i>Cornie</i> Middle <i>Mae</i> Last <i>Watkins</i>		4. DATE OF DEATH Month <i>11</i> Day <i>20</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>E</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 15/58</i>
9. AGE (In years last birthday) <i>5</i> yrs.		IF UNDER 1 YEAR Months <i>5</i> Days <i>5</i>	IF UNDER 24 HRS. Hours <i>5</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>MD</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Jos. Watkins</i>		14. MOTHER'S MAIDEN NAME <i>Mathe Randle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mathe Randle</i> Address <i>Durham</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition and pneumonia</i> 772.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had not eaten food</i>		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>11-22-56</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Coopers</i>		22d. LOCATION (City, town, or county) (State) <i>Calvert, MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. Z. Sewell</i> ADDRESS <i>P. Fred, MD</i>		24a. REC'D BY REGISTRAR <i>DATE 11-22-56</i>	
24b. REGISTRAR'S SIGNATURE <i>N. Z. Ward</i>			

2064327XV5

NOV 26 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11173

11180 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Cabret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS _____			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>L.</u> Last <u>WOOD</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1871</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Cabret Co., Ind</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William C. Wood</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Monnett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mr. Harry Connor - Baltimore, Ind</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> <u>831X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>6</u> <u>10</u> -----, 19 <u>37</u> , to <u>11</u> <u>29</u> -----, 19 <u>56</u> , that I last saw the deceased alive on <u>11</u> <u>28</u> -----, 19 <u>56</u> , and that death occurred at <u>1 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. J. Weems</u>				ADDRESS (Street, city or town, state) <u>Huntingtown Md</u> DATE SIGNED <u>12/1/56</u>			
PHYSICIAN'S NAME (Type) <u>G. J. WEEMS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore - Cabret Co. - Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Smithfield, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>H. W. Ward</u> DATE <u>12-1-56</u>		24b. REGISTRAR'S SIGNATURE _____	

